

Supreme Court U.S.
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IN THE
Supreme Court of the United States

KYLE G. BROWNFIELD, PETITIONER

v.

METROPOLITAN LIFE INSURANCE COMPANY

*PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT*

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Insurance companies have been inappropriately denying claims for benefits under disability policies for years. This practice was made even worse when the "Treating Physician Rule" was effectively killed by the U.S. Supreme Court in *Black & Decker v. Nord* (2003). Subsequently, insurance companies have become even more brazen in denying disability claims. The absence of good law protecting disabled people is so lacking that the New York State Attorney General Eliot Spitzer went after UnumProvident – one of the worst offenders. In a landmark settlement reached on November 19, 2004, UnumProvident agreed to impose sweeping reforms that will protect disabled workers under their policies. John Garamendi, the California Insurance Commissioner, initiated a completely separate settlement agreement with UnumProvident.

Unfortunately, MetLife, unconstrained by any settlement agreement, continues to practice the same unjust claims handling procedures that UnumProvident was found guilty of and ultimately fined. MetLife, along with other insurance companies, will continue to support their unjust denial of benefits on a regular basis supported by the ruling of *Black & Decker v. Nord*.

Three questions are presented:

1. Did *Black & Decker v. Nord* increase an already serious injustice that allowed insurance companies to deny thousands of disabled persons their rightfully due benefits?

2. Should the U.S. Supreme Court resolve the dispute among the Circuits as to whether credible

evidence from outside the administrative record should be admissible to show the extent of the conflicts of interest that insurance companies have committed in denying disability benefits?

3. Is there a simple solution that will correct the existing case law now seriously affecting disabled persons?

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CIR. 1995) 25**STATUTES**

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OPINIONS BELOW

The Opinion of the United States Court of Appeals for the Ninth Circuit was unreported and is reproduced in the Appendix at 1a – 3a. The Judgment of the United States Court of Appeals for the Ninth Circuit was unreported and is reproduced in the Appendix at 4a. The Original Judgment of the United States District Court for the Central District of California was unreported and is reproduced in the Appendix at 5a. The Corrected Judgment of the United States District Court for the Central District of California was unreported and is reproduced in the Appendix at 6a. The Order Denying the Petition for Rehearing *En Banc* was unreported and is reproduced in the Appendix at 7a – 8a.

JURISDICTION

The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

The Ninth Circuit's opinion was rendered on September 14, 2005. A timely Petition for Rehearing *En Banc* was denied on November 3, 2005. Appendix 7a – 8a.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Title 29 United States Code, Section 1132

A civil action may be brought—
(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

STATEMENT

The Ninth Circuit affirmed the district court's decision to deny Petitioner's disability benefits arising under a disability plan governed by "ERISA" (Employee Retirement Income Security Act of 1975, 29 U.S.C. §1001, et seq.) In affirming the district court's denial of benefits, the Ninth Circuit was arguably handcuffed by the U.S. Supreme Court's decision regarding the "Treating Physician Rule" in *Black & Decker v. Nord*, 123 S. Ct. 1965 (2003).

In this case, the Respondent and Claims Administrator, Metropolitan Life Insurance Company, "MetLife" hired a physician-consultant to review Petitioner, Kyle Brownfield's "Brownfield" medical file. This physician made MetLife aware that certain documentation was lacking to support Brownfield's impairment. MetLife was in possession of the documentation which supported Brownfield's impairment, yet did not provide it to their hired physician-consultant. MetLife then used their physician's opinion, citing lack of supporting documentation, to deny Brownfield's claim for disability benefits. MetLife claimed they relied on *Black & Decker v. Nord*, to support their denial of benefits. MetLife's physician-consultant sided with his employer's (MetLife) denial in spite of never having

examined or spoken to Petitioner, completely ignoring the opinion of Brownfield's treating physician, and never having received the medical documentation he requested from MetLife.

In affirming the denial of disability benefits of Petitioner, the Ninth Circuit did not consider evidence outside the administrative record to show the full extent of the **many** conflicts of interest that existed when MetLife denied Petitioner's disability benefits. The Ninth Circuit's decision refusing to consider this evidence conflicts with the holdings of the Fifth Circuit and greatly prejudiced Brownfield.

CHRONOLOGY OF EVENTS:

September 27, 1976 - Petitioner, Kyle G. Brownfield was hired by Kodak.

June 12, 1980 - Dr. Stanford Noel, M.D. (Brownfield's treating physician at that time) wrote in a letter to Kodak that Brownfield had a medical condition which affected the spine and connective tissue holding her joints together, which would eventually prove disabling. When Brownfield became disabled, she provided Dr. Noel's letter from 1980 predicting her disability to both Kodak and MetLife. MetLife denied either party ever receiving it. Dr. Noel's letter from 1980 stated,

"this young woman has been under my treatment since 1975 for symptoms relating to seronegative spondylitis. She has radiographic evidence of spondylitic changes throughout the thoracic and lumbar spine. **She has also had migratory arthralgias of**

peripheral joints, which are not currently disabling.

Brownfield worked for over twenty-five (25) years at Kodak. She held the positions of Sales Representative, Regional Account Manager, Regional Sales Manager and National Sales Manager. She received many awards during that time, including being honored by the CEO of Kodak, as "Kodak Employee of the Year," a prestigious honor given only to her out of the over 6,000 employees in her division. During that time, she endured the continuing progression of that disease while missing only 6 days of work.

August 1, 2001 - she experienced sciatica (nerve pain) so severely that she was taken to Mission Hospital, where her husband required additional assistance to get her out of the car. The orderlies brought a gurney, and helped her out of the car and wheeled her into the emergency room. At the Mission Regional Imaging Center, an MRI revealed multilevel degenerative disc disease.

August 23, 2001 - Dr. Sten Kramer (her treating physician) placed Brownfield on Kodak Short Term Disability and prescribed physical therapy three times a week due to acute lumbar spine strain and degenerative disc disease of the lumbar spine.

March 4, 2002 - even though Brownfield had not worked for 7 months, she was notified that she was being laid off. Her final day at Kodak would be 17 months before she was eligible for retirement. Her contact at Kodak Benefits, Mike Pribanich, assured her

that she would have no problem qualifying for Long Term Disability.

March 15, 2002 - Brownfield applied for Kodak's Long Term Disability benefit at the same time she applied for Social Security Disability benefits.

April 4, 2002 - MetLife referred Brownfield's claim to their **in-house** nurse consultant, K. Buck.

April 9, 2002 - Ms. Buck conducted a telephone interview with Brownfield.

MetLife's Trial Brief claimed that Brownfield's Dr. Kramer was non-responsive to their requests for information. "Ms. Buck attempted to contact Dr. Kramer several times between April 9 and April 18, 2002 by faxing him questions and by leaving telephone messages."

This statement was contrary to MetLife's own internal diary which confirmed that Buck's first call to Dr. Kramer after 4/9/02 was on 4/17/02.

During the aforementioned time frame, on 04/17/2002, Ms. Buck did indeed speak with Dr. Kramer. MetLife's diary only showed one other call to Dr. Kramer left by Ms. Buck requesting that he call her back. This call took place on 04/18/2002 when Dr. Kramer's office was closed and everyone including Dr. Kramer was at lunch. Kramer's office says they returned that call.

May 1, 2002 - MetLife wrote to Brownfield denying her claim for Long-Term Disability Benefits.

Ms. Buck stated, "Based on the lack of cooperation from Dr. Kramer and failure to return my calls to discuss the file as well as the lack of objective findings, [I] feel that the medical [evidence] does not support [Plaintiff's] inability to perform the job functions of any occupation."

It is clear that MetLife's Claims Administrator (K. Buck) misrepresented actual events to support a denial of disability benefits to Brownfield.

May 3, 2002 - Brownfield called MetLife and was told over the telephone that her Long Term disability claim had been denied. A letter was not received until mid-June informing her in writing of the denial.

June 23, 2002 - Brownfield was granted Social Security Disability benefits.

August 1, 2002 - Brownfield sent documents to MetLife as shown in MetLife's internal diary. "Letter from EE [Employee (Brownfield)]. Receipt of another letter dated 7/22/02. EE has also sent in additional medical dated 6/14/2001."

August 30, 2002 - MetLife's internal diary noted:

"We have now received additional medical. - EE is a 48 y.o. female who worked as a sales rep for Kodak for 24 years. Disability is chronic left SI joint dysfunction, chronic discogenic neck pain, degenerative disc disease/spondylosis C3-C4-5, chronic thoracic strain, multilevel degenerative disc paracentral disc bulge L5-S-1 and hypoplastic fusion L4-5, and spastic bladder syndrome. The

5/9/02 medical that we just received indicates that the claimant returned complaining of severe back pain in the mid back and lower back regions. **His** medications are Lodine, 400 mg b.i.d., Topamax 50 mg o.h.s., and Zanaflex 2-4 mg at night. Dr. Clifford Bernstein recommended that the claimant have prolotherapy injections to the left SI joint. On 5/10/02, the claimant underwent left sacroiliac joint injection with prolotherapy. On 5/30/02 the claimant returned to **his** AP complaining of severe pain again. It was recommended that **he** have injections again for **his** pain. On 5/31/02 and 6/10/02, the claimant underwent prolotherapy again with Dr. Kramer. On 7/12/02, the claimant underwent surgery of the left foot for Morton's neuroma excision. On 7/25/2002, the claimant returned to **his** AP complaining of midback pain and spastic bladder symptoms. EE is scheduled for surgical procedure for the spastic bladder in August. On 7/26/02, EE underwent catheter directed thoracic epidural steroid injections with Dr. Kramer. Please evaluate the new medical that was just received and provide an opinion on the severity of Kyle Brownfield's disability. D. Burdick."

If MetLife wasn't so busy trying to deny this appeal, they would have paid more attention to Kyle Brownfield's records and realized that **his/he** was actually a woman.

September 11, 2002 - MetLife sent a portion of Brownfield's file to their physician consultant, Dr. Richard A. Silver. MetLife asked Dr. Silver to provide answers to the following questions:

"A.) Does the available medical documentations support an impairment of such severity that would cause the claimant's inability to function at any gainful employment?

B.) If the answer to A is yes, please explain how the medical documentation supports impairment and advise what impairments the claimant has.

C.) If the answer to A is no, please advise what documentation is lacking to support an impairment."

10/1/2002 - MetLife's medical consultant, Dr. Silver stated to MetLife:

"Ms. Brownfield has never had an EMG, nerve conduction velocity study completed, or an orthopedic surgical spine specialist consultation completed. She has not had a myelogram or myelographically enhanced UT scan performed. Dr. Silver went on to say, "... it would be prudent for Ms. Brownfield to see a board-certified neurosurgeon and a board-certified neurologist. **It would be appropriate for Ms. Brownfield to have an EMG and nerve conduction velocity studies performed.**"

Unbeknownst to Dr. Silver, he was never given the complete file on Brownfield! The suggested tests had already been performed and were already in MetLife's files! The Administrative Record of MetLife's confirmed that there were x-ray findings done on 8/9/01. There were myelograms done on 8/3/01 and 11/7/01. There were also nerve conduction

studies done on 12/28/01 and reported 6/10/02. All of the above documents confirmed abnormalities. All of the tests Dr. Silver stated hadn't been performed were already in the Administrative Record and were in MetLife's possession before they engaged Dr. Silver. Copies of these documents were later sent to Brownfield from MetLife when she requested a complete copy of her file.

Lacking this requested information to form an accurate opinion, Dr. Silver, who it turns out is not even licensed in the state he practices medicine, tells MetLife (his employer) that based on the medical evidence provided to him or lack thereof, he can not determine that Brownfield is disabled!

During the final months leading up to MetLife's decision to deny disability benefits, Brownfield's employer "Kodak" (out of whose pocket would come the payment of benefits) conspired to deny Brownfield's disability benefits by calling **every week** and forming such an affinity for Kodak's representative, "Mike" that they were on a first name basis.

From MetLife's internal diary:

"09/16/2002 INCOMING CALL FR [from] ER [employer] MIKE PRIBANICH, ADVISED THAT APPEAL IS STILL PENDING."

"09/24/2002 INCOMING CALL FROM ER [employer] MIKE PRIBANICH CALLED FOR STATUS OF APPEAL."

"09/30/2002 INCOMING CALL FROM ER [employer] FR MIKE PRIBANICH, ADVISED CURRENTLY STILL UNDER REVIEW AT THE APPEALS LEVEL."

"10/08/2002 INCOMING CALL FROM ER [employer] FR MIKE PRIBANICH, STATUS OF APPEAL. ADVISED MIKE APPEAL HAS BEEN UPHELD [benefits denial] & LETTER WENT OUT DATED 10/3/02."

"10/15/2002 INCOMING CALL FROM ER [employer] SPOKE TO MIKE PRIBANICH, HE INDICATED HE SPOKE TO EE [Employee - Brownfield] WHO ADVISED HIM SHE HAD CALLED OUR OFFICE FOR INFORMATION & HAS NOT HEARD ANYTHING FROM US... ADVISED THE UPHOLD LETTER WENT OUT TO EE [Brownfield] ... MIKE SAID HE WILL CALL EE & ADVISE HER TO SEND REQUEST IN WRITING."

From the above, it is clear that Kodak wanted to save money and MetLife wanted to keep a valuable client (Kodak) - a win/win for both.

Immediately after the above listed series of events, EKINSELLA@METLIFE.COM from MetLife notified TAMMY.ROY@KODAK.COM from Kodak of Brownfield's denial of benefits, Kodak thanked MetLife for denying the claim:

"E-MAIL SENT TO ER - LTD DENIAL NOTIFICATION. LTD DENIAL"

"THANKS, WE WILL NOTE ON HER FILE HERE"

MetLife closed the administrative record with the final denial.

March 13, 2003 - Brownfield filed a complaint in this action.

April 17, 2003 - MetLife answered the complaint.

October 27, 2003 - Brownfield filed its Response and Memorandum of Points and Authorities regarding Trial on the Administrative Record.

November 26, 2003 - A trial on the administrative record was heard by the district court.

April 7, 2004 - The Court mistakenly issued a judgment on a non-existing motion for summary judgment.

April 13, 2004 - The district court issued a corrected judgment to reflect the fact that the matter was heard as a trial on the administrative record.

May 5, 2004 - Brownfield's Notice of Appeal was timely filed.

REASONS FOR GRANTING OF THE PETITION**I. THE SUPREME COURT'S RULING IN
BLACK & DECKER v. NORD HAS
CREATED FURTHER PROBLEMS IN
ADMINISTERING DISABILITY
CLAIMS**

The Supreme Court's ruling in *Black & Decker v. Nord*, 123 S. Ct. 1965 (2003) is now the leading case affecting disability law. A review of the oral arguments before the U.S. Supreme Court and the later actions that both the New York State Attorney General, Eliot Spitzer and the California Insurance Commissioner, John Garamendi were forced to take, clearly shows the devastating consequences that Black & Decker has had on those that become disabled. These unintended consequences have worsened the already serious injustice that continues to allow insurance companies to deny thousands of disabled persons their rightfully due benefits.

**THE SUPREME COURT OF THE UNITED STATES
ORAL ARGUMENT**

**Black & Decker Disability Plan, v. Kenneth L. Nord
- Case No. 05-469**

On Monday, April 28, 2003, Lee T. Paterson appeared before the U.S. Supreme Court on behalf of the Petitioner, Black & Decker, and stated:

"The Ninth Circuit has adopted a treating physician rule in ERISA cases which requires the plan administrator to either accept the opinion of a treating physician or to reject that opinion by

specific legitimate reasons based upon substantial evidence. The Ninth Circuit says that this rule gives special weight, deference, and a presumption to the opinions of treating physicians...

The Secretary of Labor has adopted regulations, which were effective in January 1 of 2002, which requires a plan administrator to obtain the opinion of an expert medical professional to advise him regarding medical opinions and to be able to provide an expert medical opinion to the claimant if he requests it...

There has always been a requirement under ERISA and the regulations that plan administrators explain the reasons for his denial of a claim... They were given by the plan administrator in writing to the claimant. He told the claimant that he was, in fact, denying the claim based on the opinion of Dr. Mitri... He told them that part of the reason for denying the claim was the fact that the plan administrator had asked the claimant to please have his treating physicians comment on the opinion of Dr. Mitri. He did that twice. He did it in writing. And in neither case did the respondent respond with any - from the treating physicians - with any response from their - the treating physicians."

Justice Ginsburg stated:

"Why was it so clear? First of all, if you take the treating physician - was given an opportunity to comment on the expert's opinion, on Dr. Mitri's opinion. Here it is. Not one word from either the treating physician or the - what is it? The

orthopedist who was – who was called in by the treating physician. So the expert stands out there all alone with no comment on it.”

The facts of Brownfield’s case are quite different from Black & Decker v. Nord. Both Brownfield and her treating physician were unaware, until after MetLife closed the administrative record, that MetLife had even engaged a physician for an opinion. After the administrative record was closed, no other evidence was allowed to be considered by the trial judge. Brownfield gave evidence to the Court to supplement the administrative record to counter what MetLife and their physician had stated, but the court could not consider it.

During the oral argument in the Black & Decker case, Mr. Paterson stated:

“The Ninth Circuit’s treating physician rule is a categorical rule based upon the assumption that a treating physician’s opinion is superior to other medical opinions... and that the Plan administrator in the Ninth Circuit’s rule requires the plan administrator to give deference, special weight, and a presumption in favor of Dr. Hartman’s opinion even though he referred respondent to specialists for evaluation and even though he has no apparent expertise in back injuries or back pain... In every case, the ERISA plan administrator should weight not only the source of the opinion, but also the experience, the testing, the treatment, and the credentials of the physician.”

Again, the facts of Brownfield's case were quite different. MetLife would not refer Ms. Brownfield to an independent medical examiner, nor give the physician they hired for an opinion the medical evidence in their possession supporting Ms. Brownfield's case. When MetLife's physician requested the additional medical documentation in MetLife's possession, MetLife ignored him. Contrary to what Mr. Paterson claimed should be done in "every case", the plan administrator in Brownfield v. MetLife did not weight "the source of the opinion," "the experience, the testing, the treatment or the credentials" of their own physician. Their physician did no testing or treatment and was unable to properly evaluate the majority of the medical evidence, because it was never provided to him by MetLife. Neither the plan administrator, Kodak nor MetLife, even checked MetLife's physician's credentials. If this had been done, they would have found that MetLife's physician did not have a license, nor could he renew his license in the state he stopped practicing medicine due to the malpractice decisions against him and his disciplinary record by the Arizona Medical Board.

Since Black & Decker v. Nord, the courts in the Ninth Circuit have effectively checked to see if the plan administrator had a physician's opinion claiming that the disabled claimant was not entitled to disability benefits. Once the Judge finds that there was the above physician's opinion, the courts will automatically rule for the insurance company.

This was clearly apparent in the Brownfield case. After MetLife claimed that they were relying on the opinion of their physician, the court did not even

comment on anything in Brownfield's briefs, but took MetLife's Statement of Fact and Conclusions of Law nearly verbatim and inserted it into an opinion on a nonexistent Motion for Summary Judgment replete with many other errors. A corrected ruling was subsequently filed for the trial on the administrative record. Both rulings were rubber stamped with the presiding judge's name.

As previously stated by Mr. Paterson, "The Ninth Circuit has adopted a treating physician rule in ERISA cases which requires the plan administrator to either accept the opinion of a treating physician or to reject that opinion by specific legitimate reasons based upon substantial evidence."

The treating physician rule, as adopted by the Ninth Circuit, may have had a negative aspect in regards to the treating physician possibly being a bit biased for their patients. However, it did have the effect of providing substantial justice. Requiring "the plan administrator to either accept the opinion of a treating physician or to reject that opinion by specific legitimate reasons based upon substantial evidence," had the effect of causing the always conflicted plan administrator to actually present evidence to support their denial of disability benefits. If this is done and the treating physician is notified of his reasoning, the treating physician gains a chance to explain or counter the plan administrator's physician's opinion. In Brownfield's case, her treating physician would have notified MetLife's physician that MetLife had not provided him (MetLife's physician) with most of the pertinent medical examinations or findings. Prior to its demise, the treating physician's rule would assure that

real justice was received by thousands, and potentially millions, of truly disabled persons.

Brownfield's case is a perfect example of how insurance companies have learned to manipulate a body of laws established to protect the disabled in order to deny benefits to thousands of truly deserving, whom by no fault of their own, can no longer work.

The U.S. Supreme Court stated in its decision in *Black & Decker v. Nord*, 123 S. Ct. 1965 (2003) "Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician ... nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation."

In Brownfield's case, MetLife arbitrarily closed the administrative record thereby preventing Brownfield's reliable evidence from being heard by the court. Attempting to have this evidence heard, Brownfield submitted to the court reliable evidence including the opinions of her treating physician to supplement the administrative record, but the courts would not consider it.

Additionally, MetLife's consultant's opinion could not be considered "reliable evidence" because MetLife did not provide their consultant with the critical information in their possession for him to form an educated opinion.

After *Black & Decker v. Nord*, insurance companies have become even more brazen in denying

disability claims. It has become so out of control, that New York State Attorney General Eliot Spitzer went after UnumProvident – one of the worst offenders. The investigations focused on assertions that UnumProvident had inappropriately denied claims for benefits under individual and group long-term disability insurance policies. In a settlement on November 19, 2004, UnumProvident agreed to impose sweeping reforms that will protect disabled workers nationwide. The settlement resolves issues relating to investigations into UnumProvident's claims handling practices. Under the terms of the settlement, UnumProvident and its subsidiaries have agreed to:

- “reassess the claims of approximately 200,000 individuals whose claims for group or individual long-term disability benefits were denied;
- restructure their claim handling procedures to ensure that all future claims are reviewed in a fair and objective manner, including an agreement to:
 - select medical examiners based solely on merit, and ensure that those examiners review all relevant records before reaching a determination;
 - require personnel making impairment determinations to certify that their determinations were based upon a review of all the relevant evidence;

- prohibit company personnel from trying to influence the outcome of disability claim appeals; and
- grant significant weight to findings of disability by the United States Social Security Administration."

MetLife operated contrary to all four of the requirements stated above in Brownfield's case, yet they are not required to follow this settlement.

The Unum lawsuit and subsequent settlement was obviously necessary due to how claimants like Brownfield were treated based upon the lack of direction and good law affecting disability claims handling procedures.

Though UnumProvident has agreed to change their claims handling procedures, as can plainly be seen from the aforementioned facts, MetLife and other insurers are continuing to practice the same unfair denial process that UnumProvident was investigated and fined for in 2004.

In the case of *Black & Decker v. Nord*, MetLife was also the insurance company. That ruling has made it easier for all insurance companies to improperly deny disability benefits. Currently, except for UnumProvident, MetLife and other insurance companies have been and will continue to deny disabled people benefits, at will, through the trickery detailed above. Because of the implications of *Black & Decker v. Nord*, the only fact the courts now needs to focus on is whether the Claims Administer obtains an opinion from

their physician that states he did not find the claimant disabled. The disabled person is then presented with the extremely difficult, if not impossible task, of overcoming the "Abuse of Discretion Standard" to prevail against the insurance company. This is like forcing a disabled person to climb Mr. Everest in a wheelchair. It is technically possible, but really can't be done.

The majority of lawsuits against UnumProvident thus far have been settled out of court and the "company says most of the cases ending up in trial are won on their end". This statement only proves how dreadful the current law is when it is forcing disabled people to settle and receive pennies on the dollar of their policies.

The class action filed against UnumProvident in San Francisco federal court also **found UnumProvident employed biased medical examiners and improperly destroyed medical reports, in addition to other reports.**

A former in-house physician at UnumProvident, Dr. McSharry, sued the company in July 2002 after being fired that previous January. McSharry says UnumProvident pressured him, as well as the other doctors, to go along with claim handlers' decisions to terminate claims. Dr. McSharry says he was fired after he refused to sign off on claims.

On the television news show 60 Minutes, UnumProvident's bad faith business practices were disclosed by former Unum employees and have been confirmed by over a dozen current and former

employees including former vice presidents of UnumProvident. The former employees disclosed information on UnumProvident saying the workers were told they must meet monthly targets that would come from the directors or above as to the sum of money that must be met by the end of the month in closures.

In 2003, shortly after the ruling in Black & Decker, California Insurance Commissioner John Garamendi began an exhaustive investigation into allegations of unfair claims settlement practices by the Tennessee-based UnumProvident. The investigation uncovered more than 25 business practices that violated California law, including:

- Knowingly applying the wrong definition of "total disability" in claims handling;
- Selectively and inappropriately using independent medical exams and other medical information to the company's own advantage.

In 2005, UnumProvident settled with the California Insurance Commissioner and was required to pay an \$8 million fine. The agreement settles a dispute over thousands of claims by California policyholders who were unfairly denied benefits. UnumProvident will change its policy language and claims handling procedures in dealing with those disputed claims, and all future claims.

Commissioner John Garamendi announced that the settlement will:

“significantly improve consumer protection and profoundly impact how disability policies are handled in California...This is a new day for policyholders whose disability insurance claims have been wrongly denied by insurance companies. I am making it clear today that policies sold in California will deliver what they promise. In this state, insurers will live up to their end of the bargain.”

Important aspects of the settlement include:

- A higher standard must be met for the insurer to reject a claimant's doctor's opinion on disability, and the reasons must be documented in claim files;
- Claimants or their doctors may request an independent medical examination.

MetLife was the insurance company and Claims Administrator in Brownfield's case. After Unum's California settlement, if Brownfield had Unum as the Claims Administer, her doctor's opinion would not have been ignored under *Black & Decker v. Nord*, but would have had “a higher standard” of review. Brownfield was forced into the Black & Decker “Abuse of Discretion” review standard. Brownfield requested an independent medical examination on numerous occasions, but was denied. MetLife did and continues to do everything for which UnumProvident has been fined and has agreed not to do again.

The Supreme Court of the United States should recognize that there is still a major problem with the laws affecting the disabled. The Court should be part of

the solution and not part of the problem. The Court should now understand that their decision under *Black & Decker v. Nord* has only made the problem worse for disabled people. **Disabled people should not have to wait for State Attorney Generals and State Insurance Commissioners to receive justice.**

II. REVIEW IS WARRANTED TO RESOLVE AN IMPORTANT DISPUTE AMONG THE CIRCUITS

During the Brownfield case, MetLife frequently used the phrase, "There is no evidence in the administrative record to support ..." Their use of this phrase was especially harmful to Petitioner's case when used in reference to issues involving their own conflicts of interest. For example, MetLife claimed among other points that Brownfield's treating physician's informed MetLife's claims administrator that he could not be objective. This was a complete fabrication. Brownfield's physician prepared a statement countering that assertion, yet it was not allowed into evidence. Also, not allowed into evidence was a letter sent to MetLife by Brownfield's doctor, where it was kept in both Brownfield's and Kodak's personal file. That letter predicted her condition decades before it actually manifested itself. Just like the documents that MetLife's physician consultant requested, that were already in their files, MetLife denied ever having received that document. Also not admissible was documentation clearly showing that the physician/consultant, whom MetLife used to support their case, was not licensed to practice medicine in the state he claimed. To make matters worse, that same physician/consultant had numerous medical complaints

and malpractice judgments against him. All these important and crucial facts were not allowed into evidence.

The Fifth Circuit recognizes the impossibility of proving a conflict of interest on the part of a plan administrator without going beyond the administrative record. See *Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346, 356 (5th Cir. 2004) ("There is no practical way for the extent of the plan administrator's conflict of interest to be determined without the arbitrator going beyond the record of the administrator.") The Ninth Circuit in general and the district court in this particular case take the opposite view. Indeed, in her opening brief to the Ninth Circuit, petitioner documented numerous examples of conflicts of interest on the part of Respondent. Some, if not all, of the evidence necessary to prove such a conflict was outside the administrative record.

The Fifth Circuit allows a plaintiff to go outside the administrative record to determine the level of conflict of interest that existed. The Fifth Circuit would have allowed Brownfield's physician's statement countering the fabrications that MetLife has attributed him. The Fifth Circuit would have allowed the introduction into the administrative record of the physician's document which predicted the genetically passed on auto immune disease that Brownfield now suffers. The Fifth Circuit would also allow information to supplement the administrative record regarding the fact that MetLife used an unlicensed consultant to determine Brownfield's medical condition and therefore deny benefits.

As pointed out, *supra*, the Fifth Circuit allows evidence outside the administrative record to show how a plan administrator administered a claim under a conflict of interest. *Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346, 356 (5th Cir. 2004). In contrast, the Ninth Circuit places limits on the admissibility of evidence considered "outside" the administrative record. *Mongeluzo v. Baxter Travenol Long Term Disability Ben. Plan*, 46 F.3d 938, 944, 943 (9th Cir. 1995). In Brownfield's case, the district court was presented with substantial evidence by Petitioner's treating physicians indicating that she was in fact disabled. Additionally, Petitioner presented a substantial amount of evidence indicating that Respondent was conflicted as a claims administrator

More importantly, if the Ninth Circuit had followed the same decisions as the Fifth Circuit, they would allow in additional information outside the administrative record on the issue of conflict of interests with the effect of raising the standard to the "Heightened Scrutiny Standard." Applying this standard, the Ninth Circuit would have reversed the District Court's decision awarding disability benefits to Brownfield.

III. THERE IS A SIMPLE SOLUTION TO CORRECT THE EXISTING PROBLEMS AND LACK OF GOOD LAW NOW SERIOUSLY AFFECTING DISABLED PERSONS

Bias and greed are the main foes to an honest administration of a disability claim. Insurance companies have nothing to loose and everything to gain

by denying a disability claim. Physicians sometimes show bias toward their clients. This includes both physicians for the Claimant and the Claims Administrator. There is a simplified solution to this bias problem that will provide substantial justice to the disabled. The following procedure should be implemented:

1. The Claimant files a claim and sends evidence of his/her disability to the Claims Administrator.
2. The Claims Administrator has a maximum of 45 days to review the claim. To ensure that all claims are reviewed in a fair and objective manner, the Claims Administer will: Select medical examiners based solely on merit, and ensure that those examiners review all relevant records before reaching a determination; Require personnel making impairment determinations to certify that their determinations were based upon a review of all the relevant evidence; Prohibit company personnel from trying to influence the outcome of disability claim appeals; and Grant significant weight to findings of disability by the United States Social Security Administration. A list of all the documents reviewed must be prepared by the medical examiners.
3. If the Claims Administrator's denies the claim, they must provide the reasons for the denial and must then send copies of all the documents in Administrator's claims file

including a list of the documents to the Claimant.

4. The Claimant has 60 days from the date of the denial to provide additional medical evidence to the Claims Administrator. The Claimant or their doctors may request an independent medical examination during this time.
5. The Claims Administrator then has 45 days from the date of the appeal to make their final determination as to whether they will pay the disability benefits.
6. If the Claims Administrator denies the appeal, the Claimant may file suit in court.
7. The court then reviews the case de Novo. The de Novo standard of review allows the court to consider all relevant evidence, similar to evaluations under Social Security disability reviews.

If this procedure looks familiar, it should. Most, if not all of it, was taken from the settlement agreements UnumProvident (the largest disability insurance company) signed in New York and California. Unum would not have agreed to this if it was not fair. This procedure will provide justice for all concerned. With the additional fairness and relevant information allowed into evidence, attorneys will not be willing to take a case on contingency if they truly do not believe they have a good chance of winning. Additionally, Claims Administrators are not going to waste their client or

stockholders money if they know that the Court will, more than likely, side with the Claimant.

State Attorney Generals and State Insurance Commissioners should not have to fix problems created with bad law. The above procedure should be followed in Brownfield's case. The court should allow MetLife's physician the opportunity to review all of the medical information. Brownfield should be able to request an independent medical examination. Brownfield's physician's opinion should be reviewed under a higher standard before being rejected. Significant weight should be given to her receiving Social Security benefits. If MetLife still denies Brownfield claim, a court should review the case de Novo.

CONCLUSION

These laws have a profound effect on disabled people's lives. There are "more than 2.5 million claims for disability benefits [filed] each year," *Cleveland v. Policy Management Systems Corp*, 526 U.S. 795, 803 (1999).

It is of exceptional importance that people who are truly disabled receive disability benefits. The disabled must have these benefits awarded in order to continue their lives and receive medical treatment. Actual survival is at stake if the disabled can no longer work and have no source of income. There should be a system of laws designed to protect disabled workers like Brownfield. Disabled people are losing their homes and their will to live when stripped of the disability benefits which are due them. These benefits are truly needed in the event of a disability to cover medical care costs and

the continuing costs required for daily living. The actual effect of the loss of disability benefits to many disabled persons is the equivalent of a death sentence.

The justices of the United States Supreme Court have the power to stop the unintended consequences of court cases that continue to severely affect disabled people lives. They have the power to unify the rulings of the clashing Circuits.

The disability laws currently existing are not working. Presented before this honorable Court is a perfect example of how insurance companies have learned to manipulate the system to benefit them and severely harm disabled people. Petitioner implores the United States Supreme Court to take the time to hear this case not only to help her, but to help the thousands, if not millions, of disabled persons who are and will continue to suffer under the current unjust law that effect the administration of disability plans.

For all the foregoing reasons, petitioner respectfully request that the Supreme Court grant review of this matter.

Respectfully Submitted,

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1a

(any footnotes trail end of each document)

No. 04-55833

**UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

KYLE G. BROWNFIELD,
Plaintiff - Appellant,

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant - Appellee.

September 14, 2005, Filed

NOTICE: RULES OF THE NINTH CIRCUIT COURT OF APPEALS MAY LIMIT CITATION TO UNPUBLISHED OPINIONS. PLEASE REFER TO THE RULES OF THE UNITED STATES COURT OF APPEALS FOR THIS CIRCUIT.

COUNSEL: For KYLE G. BROWNFIELD, Plaintiff - Appellant: Ellsworth Vines, Esq., ELLSWORTH, VINES LAW OFFICES, Irvine, CA.

For METROPOLITAN LIFE INSURANCE COMPANY, Defendant - Appellee: Joseph C. Faucher, Esq., REISH & LUFTMAN, Los Angeles, CA.

OPINION: MEMORANDUM *

JUDGES: Before: SILVERMAN and CALLAHAN, Circuit Judges, and DUFFY***, District Judge.

Kyle G. Brownfield appeals the district court's judgment, following trial on the administrative record, in favor of Metropolitan Life Insurance Company ("MetLife") in Brownfield's suit pursuant to the Employee Retirement Income Security Act ("ERISA"). We have jurisdiction pursuant to 28 U.S.C. § 1291, and we affirm.¹

Brownfield sought long-term disability benefits under a plan sponsored by her former employer, Eastman Kodak Company. Determinations of disability under Kodak's Plan are committed to the discretion of MetLife as the Claims Administrator. MetLife denied Brownfield's original benefits application and affirmed that decision following administrative review. Where the plan gives the administrator discretionary authority, the court's review is for abuse of discretion,² *Eley v. Boeing Co.*, 945 F.2d 276, 278 (9th Cir. 1991), unless the presence of a serious or substantial conflict of interest between the fiduciary and its beneficiaries is demonstrated, *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1109 (9th Cir. 1999).

In order to establish a serious conflict of interest, a beneficiary must come forward with "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995). Brownfield has failed to sustain this burden and we agree with the district court that a deferential standard of review is appropriate.

Brownfield's contention that the district court committed reversible error by neglecting its adjudicative and administrative responsibilities is wholly without merit. Finally, we decline to consider the untimely arguments raised for the first time in Brownfield's reply brief. See *Smith v. Marsh*, 194 F.3d 1045, 1052 (9th Cir. 1999) ("Arguments not raised by a party in its opening brief are deemed waived."). We affirm the district court's judgment in favor of MetLife.

AFFIRMED.

Footnotes

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir. R. 36-3.

*** The Honorable Kevin Thomas Duffy, United States District Judge for the Southern District of New York, sitting by designation.

n1 Brownfield's requests for judicial notice are denied.

n2 This circuit has been inconsistent in labeling the appropriate standard of review. Some cases refer to the standard as "arbitrary and capricious" (as used by MetLife in the Red Brief), while others use the term "abuse of discretion." Compare *Eley*, 945 F.2d at 278 (abuse of discretion) with *Dytrt v. Mountain State Tel. & Tel. Co.*, 921 F.2d 889, 894 (9th Cir. 1990) (arbitrary and capricious). "The standards differ in name only." *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1321 n.1 (9th Cir. 1995).

4a

No. 04-55833

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KYLE G. BROWNFIELD,
Plaintiff - Appellant,

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant - Appellee.

Judgment

Appeal from the United States District Court for the
Central District of California (Santa Ana).

This cause came on to be heard on the Transcript of the
Record from the United States District Court for the
Central District of California (Santa Ana) and was duly
submitted.

On consideration whereof, it is now here ordered and
adjudged by this Court, that the judgment of the said
District Court in this cause be, and hereby is
AFFIRMED.

Filed and entered 9/14/05.

5a
No. 03-280

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION

KYLE G. BROWNFIELD,
Plaintiff

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant.

Filed 4/09/2004

JUDGMENT

The Court, having considered defendant's motion for summary judgment in the above entitled matter, and the Honorable Alicemarie H. Stotler, District Judge, having duly rendered a decision on April 7, 2004.

IT IS ORDERED AND ADJUDGED that:

The plaintiff take nothing against defendant in this action, that judgment is hereby entered in favor of defendant, and that defendant recover its costs of this action.

Alicemarie H. Stotler
United States District Judge

6a

No. 03-280

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION

KYLE G. BROWNFIELD,
Plaintiff

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant.

Filed 4/14/2004

CORRECTED JUDGMENT

The Court, after trial on the administrative record in the above entitled matter, and the Honorable Alicemarie H. Stotler, District Judge, having duly rendered a decision on April 7, 2004.

7a

No. 04-55833

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KYLE G. BROWNFIELD,
Plaintiff - Appellant,

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant - Appellee.

Filed 11/3/05

ORDER

JUDGES: Before: SILVERMAN and CALLAHAN,
Circuit Judges, and DUFFY*, Senior Judge.

Judges Silverman and Callahan have voted to reject the petition for rehearing en banc and Judge Duffy so recommends.

The full court has been advised of the petition for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for rehearing en banc is denied.

Footnote

8a

* The Honorable Kevin Thomas Duffy, United States District Judge for the Southern District of New York, sitting by designation.

(3)

Supreme Court U.S.
FILED

MAR 22 2006

OFFICE OF THE CLERK

No. 05-1067

IN THE
Supreme Court of the United States

KYLE G. BROWNFIELD,

Petitioner,

—v.—

METROPOLITAN LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

**RESPONDENT'S BRIEF IN OPPOSITION TO
PETITION FOR WRIT OF CERTIORARI**

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Attorney for Respondent

CORPORATE DISCLOSURE STATEMENT
(Rule 29.6)

Metropolitan Life Insurance Company is a wholly-owned subsidiary of MetLife, Inc., a publicly-held company.

ARGUMENT

Respondent Metropolitan Life Insurance Company ("MetLife") respectfully submits its Brief in Opposition to the Petition for Writ of Certiorari ("Petition"), to correct a misstatement of fact and law contained in the Petition.

There Is No Dispute Among The Circuits Regarding Admissibility Of Evidence To Demonstrate A Claim Administrator's Purported Conflict Of Interest Where, As Here, The Disability Benefit Plan Is Funded By The Employer And Not The Administrator

Petitioner seeks long-term disability benefits under an employee welfare benefit plan sponsored by her employer, Eastman Kodak Company ("Kodak"), and governed by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.* ("ERISA"). As claim administrator for the plan, MetLife determines eligibility for and entitlement to benefits pursuant to the terms of the plan. MetLife does not fund the plan benefits. Rather, the plan is funded by Kodak. *See Petitioner's Supplemental Appendix* at 11a.

Petitioner misstates the facts and the applicable law when she contends that this Court needs to resolve a conflict among the circuits regarding whether evidence outside the administrative record may be considered to determine whether the claim administrator operated under a conflict of interest. A conflict may result in a heightened standard of review under ERISA where the same party acts both as the claim administrator and funds the benefits payable under the plan. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). By referring to MetLife as the "insurance company" throughout the Petition, (*see, e.g., Petition* at i, 22), Petitioner clearly

seeks to imply that MetLife funds the benefits at issue. Petitioner knows full well, however, that the plan at issue here is funded by Kodak, not MetLife. *See Petition* at 9 (“ . . . Brownfield’s employer ‘Kodak’ (out of whose pocket would come the payment of benefits) . . .”). There is no possible conflict of interest when MetLife makes claim decisions under Kodak’s self-funded plan.

Because of this undisputed fact, there can be no apparent conflict of interest, much less an actual conflict, both of which Petitioner incorrectly asserts. *See Petition* at i-ii, 3, 23-25. There is no dispute among the circuits as to whether evidence outside the administrative record may be considered to demonstrate a conflict of interest where, as here, the benefits are not funded by the claim administrator. By obscuring the plan’s funding source, Petitioner has misrepresented the applicable law.¹

CONCLUSION

For the foregoing reasons, Respondent respectfully requests that the Court deny the Petition for Writ of Certiorari.

Respectfully Submitted,

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¹ Petitioner’s “Chronology of Events” is also replete with factual misstatements regarding the contents of the Administrative Record. MetLife respectfully reserves the right to address these misstatements should the Court grant the Petition.

Supreme Court, U.S.

FILED

(2)

051067 FEB 1 - 2006

No. OFFICE OF THE CLERK

IN THE
Supreme Court of the United States

KYLE G. BROWNFIELD, PETITIONER

v.

METROPOLITAN LIFE INSURANCE COMPANY

*PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT*

SUPPLEMENTAL APPENDIX

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9a
No. 03-280

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION

KYLE G. BROWNFIELD,
Plaintiff

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant.

Filed 4/09/2004

FINDINGS OF FACT AND CONCLUSIONS OF
LAW AFTER TRIAL ON ADMINISTRATIVE
RECORD

I.
INTRODUCTION

On November 26, 2003, a bench trial was held based on the administrative record. The Court took the matter under submission after ordering the parties to prepare, serve, and lodge proposed findings of fact and conclusions of law. On December 5, 2003, plaintiff lodged her proposed findings of fact and conclusions of law and a re-submission of portions of the administrative record. On December 8, 2003, defendant lodged its proposed findings as well as clear copies of Bates-stamped documents 100370 through M100378.

Having read and considered the parties' papers

submitted before and after trial, as well as the arguments of counsel at trial, the Court finds that defendant did not abuse its discretion when it denied plaintiff's long-term disability benefits.

The disability plan at issue is an employee welfare benefit plan as defined by the Employee Retirement Income Securities Act (ERISA). 29 U.S.C. § 1001, et seq. This plan confers discretionary authority upon Metropolitan Life Insurance Company ("MetLife" or "defendant") as the Plan Administrator. Under such circumstances, the administrator's decision to deny benefits is, absent a serious conflict of interest, reviewed for an abuse of discretion. The Court finds no conflict of interest. As a result, the Court confines its review to the administrative record which was before the administrator when it denied plaintiff's request for benefits.

II. FINDINGS OF FACT

Consistent with the foregoing, the Court finds the facts as follows.

1. Eastman Kodak Company ("Kodak") sponsors a long-term disability plan (the "Plan") for the benefit of its employees. The Plan provides in part as to an employee's disabling condition:

- a. The condition results in a Participant's total and continual inability to engage in gainful work; with or without reasonable accommodation; and
- b. Due to the condition, the Participant remains under the care of a licensed physician. "Gainful work" means

paid employment for which a person is, or becomes, reasonably qualified by education, training, or experience, and which is more than transitory in nature, as determined by the claims Administrator.

2. The Plan also provides that the Plan Administrator and Claims Administrator each, with respect to their respective duties and responsibilities, shall have full discretionary authority in all matters related to the discharge of their duties and responsibilities and the exercise of their authority including, without limitation, the construction of the terms of the Plan and the determination of eligibility for coverage and benefits. The Plan specifically states that judicial reversal of claims decisions is predicated upon a finding that the decision was arbitrary and capricious.

3. The version of the Plan containing the language referred to in the previous paragraph was effective July 1, 2002.

4. The Plan that was effective on January 1, 1997, but was subsequently replaced by the version of the Plan that was effective July 1, 2002, vested the administrator with discretion to determine eligibility for plan benefits as did the 2002 Plan.

5. MetLife is not the funding source of the Plan. Pursuant to the Plan, "benefits shall be paid from the general assets of the company except insofar as Benefits are paid from a trust established in accordance with Section 10.3(b)."

6. The Administrative Services Agreement between MetLife and Kodak required Kodak to establish a special bank account to serve as the funding source of

the Plan.

7. Pursuant to the Plan, it is plaintiff's burden to prove and provide evidence that she is disabled. The Plan further requires participants to submit, upon request, proof of the continuance of disability.

8. Plaintiff Kyle Brownfield ("plaintiff" or "Brownfield") was employed by Kodak from September 27, 1976, to May 2, 2002. Plaintiff was laid off on March 4, 2002, due to a "downsizing initiative."

9. Plaintiff's last position was as an as "Account Manager, Large Format Inkjet," Primarily a salesperson, plaintiff's job was relatively sedentary. Her job also required some travel via automobile and airplane.

10. Plaintiff alleges that she is disabled due to "degenerative disc disease," "thoracic and lumbar back pain," "constant muscle spasms" and "spastic bladder syndrome."

11. On June 14, 2001, plaintiff presented to Dr. Karen L. Noblett of the University of California, Irvine Women's Healthcare Center with "significant [urinary] urgency/frequency and nocturia getting up 4 to 6 times at night." Dr. Noblett found that plaintiff had a normal screening neurologic exam.

12. On August 3, 2001, plaintiff presented to Dr. Sten Kramer of the Newport Coast Medical center with low back pain and left leg pain. Dr. Kramer performed an epidural steroid injection. Dr. Kramer determined that plaintiff suffered from; (1) multilevel degenerative disc

disease of the lumbar spine, and (2) acute left sciatica. Dr. Kramer concluded that plaintiff had tolerated the procedure well.

13. An August 9, 2001 medical report states that plaintiff reported marked improvement in low back pain.

14. On August 15, 2001, Dr. I.A. Hirbawi performed an MRI of plaintiff's lumbar spine. Dr. Hirbawi found normal anatomical alignment of the lumbar spine. He also stated that plaintiff had a mild congenital hypoplasia of the L4 and L5 vertebral bodies which appeared partially fused and normal bone marrow signal intensity.

15. On August 23, 2001, plaintiff returned for her follow up examination with Dr. Kramer. He reached the same impression as reported on August 9, 2001. Plaintiff continued to describe low back pain without radicular pain and Dr. Kramer recommended a lumbar stabilization program as part of a physical therapy regimen, that plaintiff discontinue taking ibuprofen, and that she return for follow up in two weeks.

16. On September 6, 2001, plaintiff returned for another follow up examination with Dr. Kramer. Plaintiff reported improvement in her lower back pain, but continued to experience mid-back pain and that she attended physical therapy and continued to see her chiropractor almost daily. Dr. Kramer diagnosed (1) chronic discogenic neck pain, (2) degenerative disc disease/ spondylosis 3-4 and C4-5, (3) chronic thoracic strain, (4) multilevel degenerative disc disease/spondylosis of the thoracic spine, (5) discogenic

low back pain and (6) left paracentral disc bulge L5-S1 and hypoplastic fusion L4-5. He recommended that plaintiff continue physical therapy but discontinue chiropractic care and that she return for follow up in two weeks. This same diagnosis was indicated by Dr. Kramer on September 19, 2001. Dr. Kramer also recommended that plaintiff have an MRI thoracic spine.

17. On September 28, 2001, Dr. Jamshid Tehranzadeh, performed an MRI of plaintiff's thoracic spine. Dr. Tehranzadeh diagnosed degenerative disc disease and bulging annulus fibrosis at T6-7, T8-9, T10-11 and T11-12 with posterior thickening of the ligamentum flavum. He found a slight impingement of the bulging annulus at T6-7 over the spinal cord. He also noted Schmorl's nodes at several levels including T10, T11 and T12, which may suggest mild Schuermann disease.

18. On October 3, 2001, plaintiff returned for a follow up examination with Dr. Kramer, whose diagnosis remained consistent with the September 6, 2001 attending physician's report. Plaintiff continued to report improvement in low back pain, but described sharp pain throughout her mid-back region.

19. On October 10, 2001, Dr. Paicius administered a thoracic epidural steroid injection. On October 22, 2001, plaintiff returned to Dr. Kramer for a follow up examination reporting "marked improvement in mid-back pain following the thoracic injection done two weeks ago." Dr. Kramer's diagnosis remained consistent with that of his September 6, 2001, examination.

20. On March 5, 2002, Dr. Kramer completed an

attending physician's statement of functional capacity. His diagnosis was "chronic discogenic LBP [lower back pain], DDD [degenerative disc disease] C3-4, LS disc bulge" and "thoracic strain." He noted that plaintiff "continues to complain of left buttock pain extending up the left flank." As to objective findings, Dr. Kramer only noted "Palpation over the thoracolumbar spine is diffusely tender" and referred to his office notes. He noted that plaintiff could lift 0-15 pounds up to 1/3 of her workday. He also stated that plaintiff could walk 10-15 minutes, sit 15 minutes and stand 15 minutes. He concluded that plaintiff was totally disabled from her own occupation and any occupation, but could resume work activities in 6 months.

21. In her Personal Profile Evaluation Form dated March 1, 2002, plaintiff states that she participated in physical therapy three times a week.

22. A job description completed by plaintiff's employer states that her job as an Account Manager, Large Format Inkjet, requires sitting and standing 20-80% of the day and requires walking 20 or less. Plaintiff's employer noted that, as primarily a salesperson, the job requires travel to customer sites via automobile and airplane depending on proximity. Daily verbal and or written communication is essential. Product sampling and demonstration is also required at customer sites or at trade shows. At most, plaintiff's job requires that she lift 0-15 pounds less than 20 of the day.

23. Plaintiff reports attending physical therapy three times per week. She submitted the reports from the physical therapy treatments to MetLife. However, the reports provide no clinical data regarding plaintiff's purported condition and only document plaintiff's

subjective complaints of pain and physical therapy administered to help treat that pain.

24. On April 4, 2002, MetLife referred plaintiff's claim to MetLife's in-house nurse consultant, K. Buck. On April 9, 2002, Ms. Buck conducted a telephone interview with plaintiff.

25. On April 9, 2002, Buck concluded that, in her opinion, the objective findings in the medical records did not correspond with plaintiff's complaints. Thus, she concluded that the objective medical information available in plaintiff's medical records did not support a continued finding of disability.

26. On May 1, 2002, MetLife wrote a letter to plaintiff which denied her claim for long-term disability benefits. The letter explained that it had reviewed her eligibility for long-term benefits and that, based on the medical information provided, there was a lack of evidence of a severe condition that would render her disabled as defined by the Plan. MetLife received plaintiff's July 22, 2002, appeal of this decision on August 1, 2002. Plaintiff questioned why the condition of her SI joint was not addressed and relied on the fact that she had been awarded social security. On August 5, 2002, MetLife wrote plaintiff and acknowledged receipt of the appeal. In that letter, MetLife requested that plaintiff submit additional medical evidence in support of her position within 180 days from her receipt of the notice of denial of her claim.

27. On May 10, 2002, Buck called and spoke with Dr. Kramer. During this conversation he indicated that he was personally involved in plaintiff's case due to his

relationship with her husband. He further stated that there was no objective medical evidence to support plaintiff's complaints of back pain. 28. On May 30, 2002, plaintiff returned for a follow up examination with Dr. Kramer, whose diagnosis remained consistent with the September 6, 2001, attending physician's report, except that he now also diagnosed plaintiff as suffering from chronic left SI joint dysfunction. He noted that plaintiff reported considerable improvement in low back pain and left buttock pain for approximately two weeks following left SI joint Prolotherapy done on May 10, 2002. However, he stated that over the last two days her symptoms have been progressively worsening.

29. On June 13, 2002, plaintiff returned for a follow up examination with Dr. Kramer, whose diagnosis remained consistent with the May 30, 2002 attending physician's report. Dr. Kramer noted that plaintiff reported significant improvement in low back pain and general feelings of well being and that she was using significantly lower doses of medications.

30. On July 25, 2002, plaintiff returned for a follow up examination with Dr. Kramer, whose diagnosis remained consistent with the May 30, 2002 attending physician's report, except that he also added a diagnosis of "spastic bladder syndrome." Although Dr. Kramer for the first time diagnosed spastic bladder syndrome, it appears from his report that he did not perform any physical examination which would reveal that condition. It appears that his diagnosis of that condition is based solely on Plaintiff's self-diagnosis.

31. In an August 14, 2002 letter "to whom it may

concern," Dr. Chin, who had removed a neural fibrous mass from plaintiff's left foot on July 12, 2002, explained that plaintiff had requested to have corrective surgery for her right bunion in November, 2002. Dr. Chin did not indicate that the surgery would render Plaintiff disabled and the healing time from such a procedure is typically eight weeks.

32. On October 30, 2002, MetLife referred plaintiff's file to another in-house nurse consultant, Blenda Wilson, for her review. On September 4, 2002, Ms. Wilson concluded that the medical information did not support a severity of impairment which prevented plaintiff from doing the light activities of her job.

33. On September 11, 2002, MetLife referred plaintiff's file to two independent physician consultants specializing in urology and orthopedic surgery for their review regarding plaintiff's restrictions and limitations. In the inquiry forms to the physician consultants, defendant specified that its focus was on defining plaintiff's level of functionality and abilities.

34. MetLife asked the physician consultants to provide responses to the following questions: A. Does the available medical documentation support an impairment of such severity that would cause the claimant's inability to function at any gainful employment? B. If the Answer to A is yes, please explain how the medical documentation supports an impairment and advise what impairments the claimant has. C. If the answer to A is no, please advise what documentation is lacking to support an impairment.

35. On October 1, 1999, Dr. Richard A. Silver, Board

Certified in Orthopedic Surgery, presented his report to defendant. He concluded that, based on the medical records provided, plaintiff had a mild impairment. The MRI objective findings were consistent with her age and did not show any evidence radiologically of a neurological deficit. Thus, he found plaintiff capable of gainful employment. He recognized that she was suffering from back pain, but found that there was a lack of evidence to support a finding of disability.

36. In his opinion, based on the medical records, the work-related activities plaintiff would need to avoid were repetitive bending and stooping, lifting, and climbing ladders or working at unprotected or unrestricted heights or around moving machinery. He also noted that from an orthopedic perspective, plaintiff could sit, stand and walk, for a total of 5-7 hours per 8-hour work day and could continuously engage in each of these activities for 2-4 hours per 8-hour work day. He also noted that plaintiff could carry 20 pounds maximum and frequently lift up to 10 pounds in an 8-hour work day.

37. On October 1, 1999, Dr. Robert Kaplinsky, Board Certified in Urology, presented his report to defendant. He concluded that, from a urology perspective, there was no objective data to suggest that plaintiff could not perform any of her stated duties. He added that the medical documentation did not support an impairment of such severity that would prevent plaintiff from functioning at any gainful employment.

38. From a urologic perspective, Dr. Kaplinsky noted that Plaintiff could sit, stand and walk, for a total of six hours per 8-hour work day and could continuously

engage in each of these activities for two hours per 8-hour work day. He also noted that plaintiff could carry 20 pounds maximum and frequently lift up to 10 pounds in an 8-hour work day.

39. On October 3, 2002, MetLife wrote a letter to plaintiff explaining that it had reviewed her claim file and that it had determined that the medical evidence did not support a finding of disability, which would preclude her from engaging in any type of work as defined by the Plan. Defendant detailed in the letter the conclusions of both Dr. Silver and Dr. Kaplinsky. Defendant also addressed plaintiff's award of social security benefits and explained how the awarding of those benefits did not guarantee the approval of long term disability benefits under the Plan as plaintiff was required to submit medical evidence substantiating the existence of a totally disabling condition as defined in the Plan. Accordingly, defendant informed plaintiff that it was affirming its original determination that she was not eligible for benefits.

III.

CONCLUSIONS OF LAW

1. The Plan is an employer-sponsored welfare benefit plan governed by ERISA.
2. The Court has jurisdiction over plaintiff's claims.
3. A denial of ERISA-regulated plan benefits is reviewable under the abuse of discretion standard if the plan accords the claims administrator "discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S. Ct. 948,

103 L.Ed.2d 80 (1989).

4. In order for the abuse of discretion standard to apply to the claims administrator's decision, the governing documents must demonstrate that the administrator "unambiguously retained" discretion to determine eligibility for benefits. *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1090 (9th Cir. 1999).

5. Defendant upheld its original decision to deny plaintiff's claim for benefits on October 3, 2002; the version of the Plan effective July 1, 2002 is the Plan applicable to the Court's review of this matter. *Bolton v. Construction Laborers' Pension Trust for So. Cal.*, 56 F.3d 1055, 1058 (9th Cir. 1995) (an ERISA cause of action based on a denial of benefits accrues at the time the benefits are denied.); *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F. 3d 1154 (9th Cir. 2001).

6. The Plan specifically designates defendant as the Plan's claims administrator and Kodak has delegated to MetLife discretionary authority to determine Plaintiff's claim for benefits. *Madden v. ITT Long Term Disability Plan*, 914 F.2d 1279 (9th Cir. 1990).

7. The Plan documents, including the Group Insurance Certificate and the Summary Plan Description, unambiguously confer discretion upon MetLife to interpret the terms of the Plan and determine eligibility for benefits.

8. Moreover, even if the Plan language from the 1997 agreement, which allows the plan administrator to delegate to the claims administrator complete discretionary authority to construe the plans as to

eligibility for participation and benefits, was applicable to the Court's review, such language is sufficient to trigger a review for an abuse of discretion.

9. Where an ERISA plan vests the administrator with discretionary authority to determine benefit eligibility, the court may review the administrator's determination only for an abuse of discretion. *Taft v. Equitable Life Assurance Soc.*, 9 F.3d 1469, 1472 (9th Cir. 1994).

10. Defendant's benefit determination is subject to an abuse of discretion standard.

11. Where the insurer has discretionary authority to interpret and apply the terms of the plan, plaintiff must put forth material probative evidence, beyond the mere fact of an apparent conflict of interest, showing that the insurer's self-interest caused a breach of fiduciary obligations. *Alford v. DCH Found. Group Long-Term Disability Plan*, 311 F.3d 955, 959 (9th Cir. 2002); *Lang v. Long-Term Disability Plan Sponsor Applied Remote Tech. Inc.*, 125 F.3d 794, 797 (9th Cir. 1997); *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1321 (9th Cir. 1995).

12. Here, there is no evidence of a serious conflict of interest sufficient to trigger a de novo review by this Court. *Lang*, 125 F.3d at 797.

13. Plaintiff has submitted documents outside the Administrative Record and asked the Court to supplement the Administrative Record. However, the Court's review is limited to the documents that were before defendant at the time it denied plaintiff's claim for benefits, and plaintiff is not permitted to supplement the Administrative Record. *Snow v.*

Standard Ins. Co., 87 F.3d 327, 332 (9th Cir. 1996); Taft, 9 F.3d at 1471; Kearney, 175 F.3d at 1084 (9th Cir. 1999).

14. Pursuant to the Supreme Court's decision in *Black & Decker v. Nord*, 123 S.Ct. 1965 (2003), the Court is not required to accord special deference to the opinion of Dr. Kramer, plaintiff's treating physician.

15. Defendant is not required to defer to the decisions of the Social Security Administration or rely on plaintiff's award of Social Security Disability Benefits in determining plaintiff's claim for disability benefits. See *Madden*, 914 F.2d at 1285; *Nord*, 123 S.Ct. 1965, 1971-72.

16. Vocational evidence (such as that in a hypothetical transferable skills analysis) is unnecessary when substantial medical evidence supports the conclusion that a plan participant is not disabled according to the terms of the plan. See e.g., *McKenzie v. Gen. Telephone Co. of Cal.*, 41 F.3d 1310, 1316 (9th Cir. 1994). In such cases, the district court need not remand for consideration of vocational evidence when a finding of no disability under the "any occupation" standard is supported by substantial evidence even absent vocational evidence.

17. Defendant's actions do not provide any basis upon which this Court could conclude that it abused its discretion when it denied plaintiff's claims.

18. Defendant's benefit determination, pursuant to which it discontinued payment of benefits to plaintiff, is upheld.

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III.

CONCLUSION

For the foregoing reasons the Court finds that defendant did not abuse its discretion when it denied plaintiff's long-term disability benefits.

IT IS SO ORDERED.

IT IS FURTHER ORDERED that the Clerk shall serve a copy of this order on counsel for all parties in this action. The Clerk shall enter judgment for defendant.

DATED: April 9, 2004.

s/

ALICEMARIE H. STOTLER
UNITED STATES DISTRICT JUDGE